FRANKLIN SPECIAL SCHOOL DISTRICT
SEIZURE INDIVIDUALIZED HEALTHCARE PLAN

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PARENT/GUARDIAN TO COMPLETE THE SECTION BELOW

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Student Name: ____ Date of Birth:________________________
Father's Name:____ Home Phone:________________________
Cell Phone: ____ Work Phone:________________________
Mother's Name:____ Home Phone:________________________
Cell Phone: ____ Work Phone:________________________
Emergency Contact if parent not available:____
(Authorized to act in behalf of parents if we are unable to contact parent)
Home Phone:_________________________Cell: _________________________Work Phone:__________________________

Physician Name:______________________________Phone:________________Fax:__________________________

SEIZURE HISTORY: TO BE COMPLETED BY PARENT/GUARDIAN

Type of seizures:____
Triggers which start seizure:____
Possible seizure signs:____
Usual length of seizure:____
Describe previous seizures including frequency of past seizures and date of last seizure:
____
____
____

Please list all current medications taken at home:
____
____

- **DIASTAT MUST BE PROVIDED BY THE PARENT/GUARDIAN TO BE KEPT AT SCHOOL AND ADMINISTERED ACCORDING TO THE PHYSICIAN ORDERS BY A LICENSED NURSE.**
- **IN THE EVENT DIASTAT WITH A PHYSICIAN ORDER HAS NOT BEEN PROVIDED FOR THE STUDENT, OR THE LICENSED NURSE IS NOT AVAILABLE, THE GUIDELINES SET FORTH IN THE SCHOOL RESPONSE PLAN FOR CALLING 911 WILL BE FOLLOWED.**

EXPIRED DIASTAT MUST BE REPLACED. AN EXPIRED DIASTAT CANNOT BE ADMINISTERED AT SCHOOL.

DIASTAT MUST BE PICKED UP AT THE END OF THE SCHOOL YEAR BY A PARENT OR GUARDIAN. MEDICATIONS NOT PICKED UP WILL BE DISPOSED OF ACCORDING TO STATE REGULATIONS.

I (parent/guardian) will notify the school nurse if Diastat is administered outside of school. Diastat is not to be used more than 5 times/month and not more than once in five days. I give my consent for school authorities to take appropriate action for the safety and welfare of my child. I give my consent for school authorities to communicate with the health care providers when necessary and for the health care provider to provide this and other information regarding my child's health needs to the school nurse, principal or designated assistive personnel. I understand that health information regarding my child will be kept confidential, but shared with school personnel on a need to know basis in order to protect the health and safety of my child. I release the Franklin Special School District from any legal claim and assume full responsibility for any adverse reactions my child may suffer as a result of taking or failing to take the medication. I understand that my child will be administered medications and emergency treatment as indicated by the physician orders on other side of this form. This treatment will be administered even if a parent/guardian cannot be reached.
I agree that this individualized healthcare plan meets the needs of my child. I understand and agree that my child may be assisted with medication administration/procedures on field trips or in the absence of a school nurse by unlicensed trained personnel (such as a teacher). I understand that if emergency medications have not been provided by the parent/guardian, 911 will be called.

______________________	______________________	__________
Parent/Guardian Name	**Parent/Guardian Signature**	**Date**
______________________	______________________	__________
Nurse Name	**Nurse Signature**	**Date**

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SEIZURE INDIVIDUALIZED HEALTHCARE PLAN

Student Name: ____ Date of Birth:______________________

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PHYSICIAN TO COMPLETE THE SECTION BELOW

Type of seizures:____
Triggers which start seizure:____
Possible seizure signs:____

SCHOOL RESPONSE PLAN

*Help the student to the floor, place student on his or her side if drooling or vomiting.
*Clear any objects out of the way, move other students outside the classroom.
*Do not try to stop the seizure, hold the child down or place anything in student's mouth.
*Monitor child's breathing.
*Stay calm, note how long the seizure lasts.
*Stay with student until seizure ends. Comfort, reassure and reorient the student.
*Accompany child to nurse's office or call nurse to room.
*Clinic nurse will provide rest, medication as indicated on medication form, notify parent and document seizure.
*Other :____

CALL 911 if:
*Absence of breathing and/or pulse.
*Seizure of 5 minutes or greater.
*Two or more consecutive seizures (no consciousness between) seizures which total 5 or more minutes.
*Continued unusually pale or bluish skin/lips or noisy breathing AFTER the seizure has stopped.

DIASTAT ORDERS (IF INDICATED)

Diastat Rectal Gel ______ mg rectally p.r.n. seizure lasting greater than ____ minutes.
Call 911 following administration of Diastat.

Quanity Provided: __________ Expiration Date: ___________________
Purpose of Medication: __________________________ Possible side effects: _______________________
Other considerations, allergies or MD orders ____

Diastat will be administered only by a licensed nurse when prescribed by the physician and provided by the parents. In the absence of a licensed nurse, 911 will be called following the 911 protocol above.

I authorize school personnel to implement this Seizure Emergency Plan as described above:

______________________________	______________________________	____________
Physician Name (Please Print)	Physician Signature	Date
______________________________	______________________________	
Physician Phone Number	Physician Fax Number	